HRSA Cooperative Agreement
Local Funding Guidance
Frequently Asked Questions

Local Funding Amount

Please explain the difference between the total cooperative agreement award of $38.8 million and the population-based local funding allocation of $23.6 million.

The California Department of Health Services (CDHS) determined the amount of the HRSA cooperative agreement award that would be allocated locally as follows:

Total California grant award: $38.8 million

Funding for critical benchmarks to be achieved at the state level by CDHS, the Emergency Medical Services Authority (EMSA), and the Department of Mental Health: $11.8

Total for benchmarks activities not conducted exclusively at the state level: $27 million

Contract with EMSA to implement or partially implement Benchmarks 2-1, 2-9, 3, and 4-2: $1.8 million

Total for local activities: $25.2 million

Reserve allocation for special regional projects: $1 million

Estimated amount necessary to pay fiscal agent administrative costs (based on the assumption that statewide, local jurisdictions will spend 50% of their allocation on equipment and supplies [with no associated admin. costs] and 50% on other activities (subject to 5% administrative costs): $625,000

Total allocation available for local direct costs: $23.6 million

CDHS has posted the application and budget we submitted to HRSA on the California Health Alert Network (CAHAN), in the documents folder at https://cahan.ca.gov/org/Documents/CDC&HRSA/HRSA and https://cahan.ca.gov/org/Documents/CDC&HRSA/Joint. CAHAN is a secure network, but the local health officer in each jurisdiction has access and can download and share this information with you if you wish to see more detail on how CDHS proposed to spend funds at the state level.

Administrative Fees

How did CDHS decide to set administrative costs at five percent of the local allocation, excluding equipment and supply purchases?

The HRSA guidance places the following restrictions on the total award:

- No more than 10 percent of the total award may be budgeted as indirect costs;
- Of the direct costs, up to 10 percent may be budgeted as operating or administrative costs;
- Of the direct costs, an additional 10 percent may be budgeted as planning costs;
- Eighty percent of the direct costs must be awarded to or directly benefit hospitals, outpatient facilities, EMS systems, and poison control.

The budget that CDHS submitted to HRSA, prior to the determination of the local funding process, placed CDHS right up against the 10 percent of direct cost administrative cap. CDHS reexamined our budget to determine where we could shift costs to be able to pay counties an administrative fee and still not exceed the 10 percent administrative cap. We made a baseline assumption that statewide, local funding requests would break down to 50 percent toward equipment and supply purchases (to which and the administrative fee does not apply) and 50 percent for other purposes. Based on that assumption, we back-calculated to the five percent administrative fee as the amount that CDHS is able to provide.

Fiscal Agency

If a county health department declines fiscal agency for the local allocation, will the county's hospitals, clinics, and EMS system still be eligible for the allocated funding?

Yes. CDHS has no plans to retract the local allocation. The local coalition should still submit a plan and budget by the January 31 deadline. CDHS will work to determine other options for fiscal agency. At the moment, CDHS does not have a mechanism to allow us to contract directly with hospitals, hospital council, clinics, or other private entities.

If the current version of SB 678 passes the Legislature in January, CDHS will be able to enter into direct contracts with private entities, exempt from the requirements of the Public Contracting Code.

Clinics

For funding purposes, what is the definition of “clinic”?

The HRSA grant guidance state that awardee health departments (i.e. the California Department of Health Services) must allocate the HRSA funds to specific types of entities. At various places the guidance refers to these entities as including “clinics” and “outpatient facilities.” The guidance further lists “community health centers, rural health clinics, federally qualified health centers, tribally-owned health care facilities serving American Indians and Alaska Natives, and other outpatient facilities that serve as vital points of entry into the health care system” as possible funding recipients.

When considering whether a particular clinic should receive funds from the local allocation, the planning coalition should consider local needs assessment data, how the clinic in question fits into the local health care delivery system, what populations the clinic serves and whether those populations are served elsewhere, and how funding the clinic will contribute to the overall preparedness of the region in relation to the critical benchmarks.

Staffing Costs

Can local coalitions use HRSA funds to hire staff?

Yes, under certain conditions. HRSA has reserved the right to approve or disapprove staffing expenditures. Funding recipients should keep in mind that the HRSA funds will not be available over the long term, so limited term positions or contract staff should be considered.

Any staff paid for with HRSA funds must be directly and solely (at least for the portion of time paid for by HRSA) engaged in implementing HRSA critical benchmarks and not in administrative activities related to the grant. For example, an acceptable staffing expenditure would be to pay for a trainer to develop a training protocol for personal protective equipment and to give that training. An unacceptable staffing expenditure would be to pay a person to do accounting, reporting, or other strictly administrative tasks related to the grant funds.

HRSA will not approve payment for staff time, overtime, or backfill staff, to attend training or participate in exercises. CDHS recognizes that this is a great need for hospitals and clinics and has discussed the issue numerous times with our federal grant officer, to no avail. CDHS has asked HRSA to carefully reconsider this stance in next year's funding guidance.

Keep in mind the prohibition against supplanting for any use of the HRSA funds. HRSA funds cannot be used to pay all or part of the salary of a staff person who is currently paid from another funding source.

Critical Benchmarks

Which critical benchmarks must local coalitions address?

Local coalitions are only required to address the six critical benchmarks listed on page five of the local funding guidance. All other benchmarks are being addressed at the state level.

As noted on page five of the guidance, local entities may choose to use up to ten percent of their allocation to address other HRSA critical l benchmarks, provided they have addressed the five required benchmarks.

Must local coalitions allocate a portion of the local funding to each of the six critical benchmarks?

> Not necessarily. Local coalitions must "address" each of the six critical benchmarks. Addressing a benchmark may mean that the application demonstrates that the local jurisdiction has already achieved the benchmark, is addressing it with funds from another source, etc.

Must local coalitions fully achieve all the six critical benchmarks?

> No. The benchmarks are final goals to work toward. For example, critical benchmark 2-1 calls for surge capacity for 500 patients per million population. If a local jurisdiction does not yet have this much surge capacity, the application should address how the jurisdiction intends to significantly increase surge capacity, even if the increase will not completely meet the target in the grant period.

Can a local coalition prorate the population-based benchmark targets to take into account the jurisdictions population?

> Yes, you should prorate the target based on jurisdiction population. If more than one jurisdiction forms a coalition to submit a single funding application, the jurisdictions can combine their populations to determine the benchmark target, and may address the target regionally. In addition, the fixed minimum target in the federal HRSA guidance for Benchmark 2-1 of surge capacity for "no fewer than 500 patients per awardee" applies to California as a whole, not each funded local jurisdiction.

Grant Period and Carryover

Can CDHS extend the grant period beyond August 31, 2004?

> No. The federal grant period ends August 31, 2004. CDHS cannot change the grant period.

Will local jurisdictions be permitted to carry over unspent funds at the end of the grant period?

> CDHS anticipates, **but cannot guarantee**, that HRSA will allow the states (and the state will likewise allow local entities) to rollover a portion of unspent grant funds at the end of the period. HRSA granted this carryover authority for the Year 1 grant funds. However, local jurisdictions should make every effort to expend funds by August 31.

Ongoing Annual Costs

Can local entities spend this year's grant funds to pay annual license fees, Internet connection fees, monthly service fees for satellite/cell phones, etc. for periods beyond the end of the grant period?

CDHS posed this question to HRSA and HRSA has stated they will not approve expenditures for multiyear contracts or to prepay ongoing annual costs.

Equipment and Supplies

Are we able to order equipment that is not listed in the 2003 Implementation Plan Optional Equipment list?

Yes, if the equipment or supply is a type not represented on the Year 1 list. Please propose the equipment or supplies you wish to buy. CDHS will make a list of requests from all jurisdictions and consult with technical experts and other advisors to determine the appropriateness of the request and establish a standard item in any given area.

Can we purchase spare equipment or supplies for training or backup purposes (spare batteries, replacement filter for masks, etc.)?

Yes.

Will equipment and supplies be directly delivered to the hospitals, clinics or EMS agencies requesting them?

Yes.

Will the grant cover storage facilities for equipment and/or the pharmaceutical cache purchased under this grant? Does it make a difference if the storage consists of building space versus portable storage containers (e.g., trailers)?

The federal guidance allows of the possibility of using HRSA funds for capital improvements, to the extent that such improvement relates to sustainable program goals. HRSA has stated they would approve renting a storage space, renting or purchasing a trailer for storage, or modifying some existing space (i.e. it would be best if the proposal uses at least one existing wall). HRSA would not support building a completely new facility, as they are concerned that such a facility may eventually be diverted to non-HRSA benchmark uses.

CDHS will consider a request to fund storage facilities subject to the HRSA advice above. Approval of any particular proposal will depend on how such a request relates to the local needs assessment data, demonstrably contributes to achieving a required critical benchmark, and is justified as a priority use for the limited funding available.

How can we find out what equipment and supplies our jurisdiction purchased with the Year 1 HRSA funds?

Both the local health officer and the local EMS agency should have this information. Please check with these sources first. If you are unable to obtain the information from these sources, you may email Cheryl Starling, R.N., at

EMSA at cheryl.starling@emsa.ca.gov. Ms. Starling can also answer technical questions about equipment on the list.

Miscellaneous

We are unable to access the HRSA guidance at the web address listed in the local guidance. Is the federal guidance available elsewhere?

Yes. The web address provided in the local guidance is for a PDF file, which you may not be able to open if your system does not have Adobe Acrobat. You can also access the federal guidance at http://www.hrsa.gov/bioterrorism/bhppguidance.htm

Must the county board of supervisors sign the application?

CDHS requires that a representative of the local health jurisdiction sign the application, along with the other three required signatories, to signify that the health jurisdiction was involved in the planning process and supports the application. Whether the board of supervisors must approve the application will depend on whether the county acts as the fiscal agency and the individual county's own requirements.

What are the responsibilities of the signatories to the grant application?

The four signatories to the application only certify that they and the groups they represent have reached agreement on the application/plan. Except for the signatory that assumes fiscal agency, the others do not incur any further obligations.

Must each entity that receives HRSA funds sign a certification of non-supplantation?

Yes. The purpose of having each recipient sign a separate certification is to relieve the fiscal agent of the responsibility to verify non-supplantation.

What is the status of the training module that was to be developed with Year I HRSA funds?

The Emergency Medical Services Authority is working with the contractor (University of California, Los Angeles), to finalize the module. It will be available to any health care provider (hospital, physician, public health officer) who wants a copy. Information on how to request a copy will be provided by EMSA when the module is available.

Can we list more than one individual on our letter of intent as a point of contact for the convener and/or the fiscal agent?

Yes. However, please indicate which person is the primary contact.

HRSA Cooperative Agreement
Local Funding Guidance
Frequently Asked Questions
Part Two
Revised

General Comments Regarding Technical Assistance

The California Department of Health Services (CDHS) has made and will continue to make a good faith effort to advise potential applicants for HRSA local funding regarding activities and purchases they may propose in their applications. Many of the scenarios posed to CDHS by applicants involve general questions about what types of activities may or may not be allowable. CDHS has done our best to answer these questions so as to assist in the application development process. However, applicants should keep in mind that final approval or disapproval of any activity or purchase will depend on CDHS and HRSA review of specific, detailed proposals and budgets.

Should CDHS or HRSA disapprove a proposal as submitted, CDHS will work directly with the local jurisdiction to address areas of concern and develop a revised proposal that will meet with CDHS and HRSA approval.

Administrative Fee

We have heard that there may be a way for an entity to receive more than the five percent administrative fee for serving as the fiscal agent for the local allocation. Is this true?

No. CDHS will not pay more than five percent of the total population-based allocation for administrative fees for acting as fiscal agent. It is possible that in a jurisdiction that proposes to use a local emergency medical services agency or hospital to act as the fiscal agent (pending passage of SB 678), the fiscal agent could receive the five percent administrative fee for administering funds to other entities and might also be the recipient of a direct amount of the grant.

Planning

Can the population-based local allocation be used for planning activities?

Planning as a concept is not excluded from allowable uses for the local allocations. However, HRSA imposed a limit of ten percent of the direct costs of the grant that may be used for planning, and many of the activities being conducted at the state level fall into the planning category. Planning activities at both the state and local level combined cannot exceed ten percent of the entire grant. Clearly, implementation activities include some degree of planning. As with any proposed activity, it will be a judgment call as to which category any particular activity falls into. We have counted all of the population-based allocation toward the required 80 percent of the grant that must be awarded to or directly benefit hospitals, clinics, or EMS systems. Our federal grant officer has advised us that HRSA does not want to see funds that California is counting as direct awards to hospitals etc., used in significant amounts to produce general

planning documents, such as a bioterrorism preparedness plan. We must demonstrate that the funds clearly benefit the target entities and make progress towards implementing critical benchmarks.

Pharmaceutical Caches

Can we purchase a pharmaceutical cache that contains other items or fewer items than those included in the Year 1 cache?

Maybe. The Year 1 cache was developed with advice from clinical experts for a defined purpose. If you believe you need a different cache, you should propose what the cache would include and describe why you wish to alter the contents of the Year 1 cache. For example, one jurisdiction suggested it may want a cache specifically for the use of first responders and their families, with fewer items than might be included in a general use cache. As with any proposal, you should justify how an alternative cache fits with your local needs assessment and addresses a required Critical Benchmark. CDHS will submit alternative cache proposals to a group of clinical experts for evaluation.

Miscellaneous

If we still have not identified a fiscal agent by the application deadline, who should submit the application?

In the absence of an identified fiscal agent, the convener of the local planning group should submit the application.

Can we use HRSA funds to purchase a van to transport equipment and supplies from place to place as needed in the event of a bioterrorist act?

No. While the earlier frequently asked questions document indicated that purchase of a trailer to store and transport equipment and supplies would be an allowable expense, the purchase of a van would raise a significant supplantation issue. Storage of the supplies in the trailer would help convince CDHS and HRSA that the trailer would not be used for non-HRSA/bioterrorism (BT) purposes. However, it would be more difficult to convince us that a van would not be used for other purposes in the absence of a BT event. Nor would it seem fiscally prudent to purchase a van that would sit unused awaiting an event. However, use of the van for other purposes would constitute supplantation.

Can we use HRSA funds to purchase a generator for a clinic?

After consulting with HRSA, CDHS has determined that you can apply for HRSA funds to purchase a generator for a clinic. Please ensure that your narrative connects the request to your local needs assessment and indicates how the generator would address one or more critical benchmarks.

Can we use HRSA funds to pay for travel, lodging, and/or per diem for staff to attend training?

Yes. Although you may not use HRSA funds to pay staff salaries, overtime, or staff backfill for training, you may use HRSA funds for travel, lodging, or per diem related to bioterrorism preparedness or response training.

Can we use HRSA funds to purchase supplies for a private ambulance company that is the contract 911 provider for the county?

Yes.